CMS Manual System

Pub 100-06 Medicare Financial Management

Transmittal 76

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: AUGUST 12, 2005

Change Request 3837

SUBJECT: Development of New Report to Capture BIPA and MMA Appeals Data

I. SUMMARY OF CHANGES: In accordance with the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 and the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the first level of appeal in the Medicare fee for service process is referred to as a redetermination. Beginning with requests received on or after October 1, 2004, intermediaries and carriers are required to process all redeterminations within 60 days. In addition, the second level of appeal will be referred to as a reconsideration, processed by a new entity, the Qualified Independent Contractor. Forwarding of requests and case files, as well as the effectuation of the QIC reconsiderations, will be handled by the contractors. The current Contractor Reporting of Operational and Workload Data (CROWD) reports used by contractors to capture appeals workload data, the CMS -2591 and 2590 reports, do not capture information on redeterminations or reconsiderations in their new format, and are not being changed to do so. As a result, CMS is developing a new report, the CMS-2592 report, to capture workload information on the redeterminations as well as the work done by contractors with regard to the QIC reconsiderations, administrative law judge and Departmental Appeals Board levels of review.

Contractors shall continue to use the CMS 2591 and CMS 2590 reports to capture data on appeal workloads received prior to the implementation date of the CMS 2592 report. The CMS 2591 and 2590 reports will be used to record appeals related data until all pending appeals workloads have been completed. In addition, the CMS 2591 and 2590 reports will continue to be used to capture reopenings data that is not clerical in nature, and as such, is not captured on the CMS 2592 report.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : *April 01, 2006
IMPLEMENTATION DATE : April 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply

only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	6/Table of Contents
N	6/460/Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form (CMS-2592)
N	6/460.1/General
N	6/460.2/Section I – Redeterminations
N	6/460.3/Section II – Qualified Independent Contractor (QIC) Reconsiderations
N	6/460.4/Section III – Administrative law Judge Results
N	6/460.5/Section IV – Department Appeals Board (DAB) Effectuations
N	6/460.6/Clerical Error Reopenings
N	6/460.7/Validation of Reports

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-06	Transmittal: 76	Date: August 12, 2005	Change Request 3837

SUBJECT: Development of New Report to Capture BIPA and MMA Appeals Data

I. GENERAL INFORMATION

A. Background: In accordance with the Medicare, Medicaid and SCHIP Benefits Improvements and Protection Act (BIPA) of 2000, and the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the first level of appeal in the Medicare fee for service process is referred to a redetermination. Beginning with requests received on or after October 1, 2004, intermediaries and carriers are required to process all redeterminations within 60 days. In addition, the second level of appeal will be referred to as a reconsideration, processed by a new entity, the Qualified Independent Contractor (QIC). Forwarding of requests and case files, as well as the effectuation of the QIC reconsiderations will be handled by the contractors. The current Contractor Reporting of Operational and Workload Data (CROWD) reports used by contractors to capture appeals workload data, the Centers for Medicare & Medicaid Services (CMS) 2591 and 2590 reports, do not capture information on redeterminations or reconsiderations in the new format, and are not being changed to do so. As a result, CMS is developing a new report, the CMS 2592 report, to capture workload information on the redeterminations, as well as the work done by contractors with regard to the QIC reconsiderations, administrative law judge and Departmental Appeals Board levels of review.

Contractors shall continue to use the CMS 2591 and CMS 2590 reports to capture data on appeal workloads received prior to the implementation date of the CMS 2592 report. The CMS 2591 and 2590 reports will be used to record appeals related data until all pending appeals workloads have been completed. In addition, the CMS 2591 and 2590 reports will continue to be used to capture reopenings data that is not clerical in nature, and as such, is not captured on the CMS 2592 report.

B. Policy:

As part of the BIPA and the MMA provisions, the first-level of appeal in the Medicare fee-for-service process will be a “redetermination”. Intermediaries and carriers will be required to process all redeterminations within 60 days. This is a change from previous statutory requirements, when intermediaries were required to process 75 percent of reconsiderations in 60 days, 90 percent in 90 days, and 95 percent of reviews in 45 days. The 95 percent requirement for reviews was also applicable to carriers.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3837.1	The contractor shall enter data on requests for redetermination in the appropriate lines and columns in the new report being developed to track changes to the appeals process resulting from the implementation of the BIPA and the MMA.	X	X	X	X					
3837.2	The contractor shall enter data on requests for and effectuation of reconsideration decisions performed by the QIC in the appropriate lines and columns in the new report.	X	X	X	X					
3837.3	The contractor shall enter data on requests for and effectuation of Administrative Law Judge (ALJ) hearings in the appropriate lines and columns in the new report.	X	X	X	X					
3837.4	The contractor shall enter data on effectuation of Departmental Appeals Board referrals in the appropriate lines and columns in the new report.	X	X	X	X					
3837.5	The contractor shall enter data on reopenings in the appropriate lines and columns in the new report.	X	X	X	X					
3837.6	The contractor shall continue to enter data on the CMS 2591 and 2590 reports for all pending appeals data received prior to the implementation of the new CMS 2592 report.	X	X	X	X					
3837.7	The contractor shall continue to enter data for all non clerical error reopenings on the CMS 2591 and 2590 reports.	X	X	X	X					
3837.8	Shared systems maintainers shall incorporate changes needed to run reports once CMS completes programming for new report.					X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
N/A	.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3837.1, 3837.2, 3837.3, 3837.4	Information and decisions from individual cases and claims at the various levels of appeal are needed for contractors to input data into the new reporting system.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: Workload data from various lines and columns in the report will interface with the Contractor Administrative Budget and Financial Management system.

D. Contractor Financial Reporting /Workload Impact: Upon release, contractors will be required to use this form to report information on appeals workload data for the redetermination, QIC reconsideration, ALJ and DAB referrals. The release will not impact Providers.

E. Dependencies: CR 3448, CR 3530, CR 3635

F. Testing Considerations: CMS will have to design and test the new report before it can be released to the contractors for use.

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Kristie McCarthy, 410-786-7139 **Post-Implementation Contact(s):** Kristie McCarthy, 410-786-7139	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Chapter 6 - Intermediary and Carrier Financial Reports

Table of Contents
(Rev. 76, 08-12-05)

460 - Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form (CMS-2592)

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

	Column 1	Column 2	Column 3
	Part A Services	Part B Services	Part B Services
	Processed by Intermediary	Processed by Intermediary	Processed by Carrier
Section I: Redeterminations			
1: Opening Pending			
2: Adjustments to Pending			
3: Adjusted Pending			
4: Requests Received			
5: Misrouted Requests Forwarded to Another Contractor			
6: Requests Cleared			
6.1 Number of Claims Cleared			
a. SNF			
b. Home Health			
c Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
7: Cleared -- Evidence Submitted after Request			
7.1: Number of Claims Involved			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
8: Affirmations			
8.1: Number of Claims Affirmed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			

9: Partial Reversals			
9.1: Number of Claims Partially Reversed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
10: Full Reversals			
10.1 Number of Claims Fully Reversed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
11: Dismissals/Withdrawals			
11.1 Number of Claims Dismissed or Withdrawn			
a. SNF			
b. Home Health			
c Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
12: Number of Incomplete Redeterminations Requests Dismissed			
13: Amount Reimbursed/Allowed			
13a. Waiver of Liability			
14: Redeterminations Processing Time –Average			
15: Redeterminations Completed in 31-60 days			
16: Redeterminations Completed in Over 60 days			
17: Redeterminations Processing Time- Average (Documentation Submitted Later)			
18: Redeterminations Completed in 31-60 days (Documentation Submitted Later)			
19: Redeterminations			

Completed in 61-74 days (Documentation Submitted Later)			
20: Redeterminations Completed in over 74 days (Documentation Submitted Later)			
21: Closing Pending Redeterminations			
22 Redeterminations Pending 1-30 days			
23: Redeterminations Pending 31-60 days			
24: Redeterminations Pending 61-74 Days			
25 Redeterminations Pending Over 74 days			
26: Total Effectuations			
26a: Number of Claims Involved			
27: Number Effectuated in 1-30 Days			
28: Number Effectuated in 31-60 Days			
29: Number Effectuated in over 60 Days			
Section II: QIC Reconsiderations			
30: Opening Pending			
31: Adjustments to Pending			
32: Adjusted Opening Pending			
33: Requests For Reconsideration Received by Contractor			
34. Requests from QIC for Case Files			
35: Number of Case Files Forwarded to QIC			
36: Number Forwarded in 5-7 Days			
37: Number Forwarded in Over 7 Days			
38: Average Time to Forward			
39. Pending Case File Requests			
40: Number of Reconsiderations Completed (and Received from QIC)			
41: Number Completed Reconsiderations that Need Effectuation			
41a. Number of claims Involved			
42: Amount Reimbursed/Allowed			

42a. Waiver of Liability			
43: Total Effectuations			
43a. Number of Claims Involved			
44. Number Effectuated in 1-30 Days			
45: Number Effectuated in 31-60 Days			
46: Number Effectuated in Over 60 Days			
47: Closing Pending Reconsiderations			
Section III: ALJ Results			
48: Opening Pending			
49: Number ALJ Requests Misrouted to the Contractor			
50: Number ALJ Cases Completed from AdQIC			
51: Number Completed that Need Effectuation			
52: Amount Reimbursed/Allowed			
52a. Waiver of Liability			
53: Total Effectuations			
53a. Number of Claims Involved			
54: Number Effectuated in 1-30 Days			
55: Number Effectuated in 31-60 days			
56: Number Effectuated in Over 60 Days			
57: Closing Pending ALJ Cases			
DAB Effectuations			
58: DAB Effectuations			

Clerical Error Reopenings

1: Total Number Clerical Error Reopenings Processed			
2. Total Number Processed – Own Motion			
3. Total Number Processed – Claimant Initiated			
4: Total Number Reopenings Resulting from Contractor Error			
5: Total Number Reopenings Resulting from Provider Error			
6. Clerical Error Reopenings at Pre-Redetermination level			
7. Clerical error reopenings at Post-redetermination level			

8: Total Number Initial Determinations Revised on Reopening			
9. Number Dismissed			
10. Amount Reimbursed/Allowed			
10a. Waiver of Liability			
11. Total number Reopening Transferred to Another Component Within Contractor			
12. Reopenings Processed in 1-30 days			
13. Reopenings Processed in 31-60 days			
14: Total Number Reopenings Pending			
15. Total Number Reopenings Occurring at Higher Level of Appeal			
15a. Total Number Higher Level Reopenings Requiring Adjustment by the Contractor			
16. Amount Awarded			

460.1 – General

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

At the end of each month, the contractor prepares and transmits to CMS a report summarizing monthly activity on redeterminations processed by intermediaries and carriers, as well as those actions associated with reconsiderations, and Administrative Law Judge (ALJ) hearings and Part A and Part B Departmental Appeals Board (DAB) effectuations that are processed by intermediaries and carriers. Contractors must complete separate reports for each office where a separate intermediary or carrier number has been assigned.

***NOTE:** The report is not designed to be completed by the Qualified Independent Contractor (QIC) or the Administrative Qualified Independent Contractor (AdQIC). All data shall be entered by the contractor. Contractors should continue to use the CMS 2591 and CMS 2590 reports to capture data on appeal workloads received prior to the implementation date of the CMS 2592 report. The CMS 2591 and 2590 reports will be used to record appeals related data until all pending appeals workloads have been completed.*

***Note:** The CMS 2591 and 2590 reports will continue to be used to capture reopenings data that is not clerical in nature, and as such, is not captured on the CMS 2592 report.*

Form CMS-2592 is subject to the Paperwork Reduction Act and requires approval by the Office of Management and Budget (OMB). OMB approval has been requested.

Purpose and Scope.--*The CMS- 2592 enables CMS to tabulate data for administrative purposes on the following information.*

- *The number of redeterminations, reconsiderations, and ALJ hearings requested, completed, and pending;*
- *The number of redeterminations resulting in affirmations or reversals of previous determinations;*
- *Timeliness Data (including processing, forwarding and effectuation data at various levels of appeal); and,*
- *Clerical Error Reopenings Data*

Unless specifically indicated, data on the CMS 2592 Report is captured in cases. Where noted, information is also requested in claims.

Due Date *-Transmit the CMS-2592 to CO via PC or terminal. Use instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.*

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

COMPLETION OF ITEMS ON FORM CMS-2592

Heading – This form is referenced as form 7 in the CROWD system. Complete the ADD/UPDATE/DELETE criteria screen with the appropriate information such as your ID Number including Business Segment Identifier (BSI), reporting month and calendar year, i.e., 12 2005 for December 2005.

General Information – Completing the Report

Refer to the information below when determining how to count and categorize data for reporting purposes.

Counting Cases -- *If an appellant submits one request involving several different claims (and several different beneficiaries), count it as one case. If the contractor receives one envelope with multiple request forms and supporting documentation, count 1 case per request received. For example, if the envelope contains 10 separate request forms with supporting documentation, count as 10 cases.*

Counting Part A, B of A and Part B Claims *If an appellant submits one request involving 5 different claims, count as 5 claims. If an appellant submits one request involving 1 claim, count as 1 claim. If the appellant submits two cases in the same*

envelope, of which one case has 3 claims and the other 4 claims, count as 7 claims. If an appellant submits a case containing 7 claims, of which 5 are requests for an appeal and the remaining 2 are determined to be reopenings, count the 5 appeal claims among the appeals workload. The remaining 2 claims should not be counted among the appeals workload, but should be counted as reopenings (see Line 1 of the Reopenings Section).

Counting Part A, B of A and Part B Cases Involving Appeals and Reopenings – *If you receive a case involving multiple claims and some claims are subject to appeal but others must be handled as a reopening, count the case as an appeal.* ***Note****: Reopenings data is captured by claims only. Because of this, no case count is recorded for reopenings.*

Additional Evidence Submitted After Request is Received -- *If you receive a case for which additional documentation is submitted for some but not all of the claims, count the case among those recorded on Line 7 (Evidence Submitted After Request).*

When to Consider a Case Reversed -- *Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.*

When to Consider a Case Completed, for Timeliness Purposes – *Consider a case to be completed when you complete the action that sets in motion correct payment of the claim* ***and*** *you mail the decision letter to the appellant.*

When to Consider a Case Effectuated *– Consider effectuation of a decision to be completed when you take the necessary actions to issue a payment to the appellant based on a fully favorable or partially favorable decision. If you take action to set in motion the correct payment of a claim (see When to Consider a Case Completed, for Timeliness Purposes) during the month of July, but payment is not issued to the appellant until August, the case is considered to be effectuated in August.*

460.2 - Section I – Redeterminations

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

This section concerns data from Part A and Part B of A appeals processed by intermediaries, as well as Part B appeals processed by carriers.

Redeterminations*. The number of redeterminations requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. Base data on actual counts of each activity and not on sampling or other estimating techniques.*

A redetermination is the first level of appeal following denial of a Part A claim or Part B claim. It is a re-evaluation of the facts and findings of a claim to determine whether the initial decision was correct. (see the Medicare Claims Processing Manual, Publication

100-4, Chapter 29, Sections 40.2, 50.1 and 60.11, as well as 100-4, Chapter 29, Sections 200 and 300 in their entirety, (currently under development and pending the Change Management clearance process).

Do not count duplicate redetermination requests or redetermination requests received before you have made an initial determination on a claim. Do not count inquiries. Count one redetermination per request received. With the exception of those lines for which claims counts are specifically requested in the report, count only cases. Do not count a duplicate request for appeal anywhere on the report. Duplicate requests can be reflected in Line 2 (Adjustment to Pending) of the CMS 2592 Report for the subsequent month.

Redeterminations fall into the following categories:

***Column (1)** Part A Cases- Use Column 1 to report information on Part A services processed by the intermediary.*

***Column (2)** Part B of A Cases- Use Column 2 to report information on Part B services processed by the intermediary.*

***Column (3)** Part B Cases- Use Column 3 to report information on Part B services processed by the carrier.*

***Line 1. Opening Pending** - Show under columns 1-3, the number of redetermination cases reported on Line 21 as the closing pending redetermination cases on the previous month's report.*

***Line 2. Adjustments to Pending** -If it is necessary to revise the pending figure for the close of the **previous** month because of inventories or reporting errors, enter the adjustment. Report requests received near the end of the reporting month as receipts in that month, even if they are not controlled until the subsequent month. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending count in the subsequent month. Examples might include inquiries that were originally classified as an appeal, a reopening claim originally classified as an appeal, a Medicare Secondary Payer case initially thought to be an appeal, or a redetermination request determined to be a duplicate of another request.*

The purpose of the Adjustments to Pending line is to allow the contractor to modify Opening Pending counts, thereby correcting errors resulting from inventory or reporting problems. As a general rule, the number of cases reported here should be very few.

Do not make adjustments to the Pending line during the same reporting timeframe. For example, if a request for appeal is received in July, it is controlled and counted as an appeal receipt for the July report. If it is subsequently determined that the case is

actually something else, do not change data on the July report. The revision is only to be reflected on Line 2 (Adjustments to Pending) of the August report.

If there is an entry for Line 2, it should be preceded by a "+" or "-", as appropriate.

***Line 3. Adjusted Pending** - Enter the result of Line 1 + Line 2 (taking into account the "-" sign, if any).*

***Line 4. Requests Received** - Show, under the appropriate columns, the number of requests for redeterminations received during the reporting month. Include requests transferred to you by other intermediaries or carriers.*

***Line 5. Misrouted Requests Forwarded to Another Contractor** - Show under columns 1 through 3 the number of redetermination requests the contractor forwarded to other contractors, because they were misrouted to you and you did not process the original claim(s). For columns 1-3, if you have reported a redetermination as forwarded, do not report any information regarding it on Lines 6-29. The forwarding of the misrouted is the final action.*

***Line 6. Requests Cleared** - Show, under the appropriate columns, the total number of redeterminations completed during the month. Report all completed appeals, regardless if the final outcome was an affirmation, reversal, withdrawal, or dismissal. Do not count cases that were transferred to another contractor because they were misrouted .*

***Line 6.1. Number of Claims Cleared –** Show the total number of claims involved in Line 6.*

***Note:** For Lines 6.1 through 11.1 (letters a through i) , enter the number and type of claim processed. If no claims from a certain claim type are processed, enter NA. **The box below is provided as an example only.** Refer to instructions for the CMS 1565 and 1566, as well as appropriate sections of the Claims Processing Manual for guidance on determining the categories and types of claims processed by intermediaries, carriers and DMERCs.*

Line 6. Requests Cleared

Line 6.1 Number Claims Cleared

a. SNF 6
b. Home Health 9
c. Inpatient Hospital NA
d. Outpatient 3
e. Lab NA

f. Ambulance NA 30
g. DME NA 12
h. Physician NA
i. Other 4

Line 6.1a – Report the number of SNF claims included in Line 6.1. Line 6.1b – Report the number of Home Health claims included in Line 6.1. Line 6.1c – Report the number of Inpatient Hospital claims included in Line 6.1. Line 6.1d – Report the number of Outpatient claims included in Line 6.1. Line 6.1e – Report the number of Lab claims included in Line 6.1. Line 6.1f – Report the number of Ambulance claims included in Line 6.1. Line 6.1g – Report the number of DME claims included in Line 6.1. Line 6.1h – Report the number of Physician claims reported in Line 6.1. Line 6.1i – Report the number of Other claims included in Line 6.1.

Consider a redetermination cleared when:

- *For affirmations, the decision letter is mailed to the parties by the 60th day (unless additional evidence is submitted after the request is received, in which case the contractor has up to 74 days to process and mail the decision letter to the parties.*
- *For partial reversals, all of the following actions have been completed:*

(1) the decision letter is mailed to the parties by the 60th day (unless additional evidence is submitted after the request is received, in which case the contractor has up to 74 days to process and mail the decision letter and

(2) the contractor completes the action that sets in motion correct payment of the claim.

- *For withdrawals and dismissals, the dismissal notice is mailed to the parties by the 60th day.*

Line 7. Cleared -- Evidence Submitted After Request - *Of the cases reported in Line 6, show under the appropriate columns, the total number of redetermination cases for which evidence (original evidence or additional documentation) was submitted after the request was received. Include those instances for which the contractor was required to develop for additional information or documentation, (for example waiver of liability and written assurance documentation, if appropriate), and the documentation was received.*

Line 7.1. Number of Claims Involved – *Show the total number of claims involved in Line 7.*

Line 7.1a – Report the number of SNF claims included in Line 7.1. Line 7.1b – Report the number of Home Health claims included in Line 7.1. Line 7.1c – Report the number of Inpatient Hospital claims included in Line 7.1. Line 7.1d – Report the number of Outpatient claims included in Line 7.1. Line 7.1e – Report the number of Lab claims

included in Line 7.1. Line 7.1f – Report the number of Ambulance claims included in Line 7.1. Line 7.1g – Report the number of DME claims included in Line 7.1. Line 7.1h – Report the number of Physician claims reported in Line 7.1. Line 7.1i - Report the number of Other claims included in Line 7.1.

Note about Lines 8-11: Use the following scenario as an example when determining how to report claims in Lines 8 through 11:

> *A case involves 5 claims. Of these claims, 3 were affirmations, 1 was a full reversal and 1 was a partial reversal.*

Count the cases in the following manner:

- *If a case has multiple claims and all are affirmed, count the case as an affirmation.*

- *If a case has multiple claims, some of which are affirmed and others are partially reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.*

- *If a case has multiple claims, some of which are partially reversed and others are fully reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.* ***Note that the example above should be counted as a partial reversal.***

- *If a case has multiple claims, all of which are fully reversed, count the case as a full reversal.*

Line 8. Affirmations *- Under the appropriate columns, show the number of completed redeterminations from Line 6 in which the previous determinations were completely upheld; i.e., no change was made. All parts of all claims in a case must be upheld in order for the case to be counted as an affirmation. (See Line 9 for partial reversals. Do not include them here.)*

Line 8.1. Number of Claims Affirmed – *Show the number of claims involved in Line 8 for which the decision was affirmed.*

Line 8.1a – Report the number of SNF claims included in Line 8.1. Line 8.1b – Report the number of Home Health claims included in Line 8.1. Line 8.1c – Report the number of Inpatient Hospital claims included in Line 8.1. Line 8.1d – Report the number of Outpatient claims included in Line 8.1. Line 8.1e – Report the number of Lab claims included in Line 8.1. Line 8.1f – Report the number of Ambulance claims included in

Line 8.1. Line 8.1g – Report the number of DME claims included in Line 8.1. Line 8.1h – Report the number of Physician claims reported in Line 8.1. Line 8.1i – Report the number of Other claims included in Line 8.1.

Line 9. Partial Reversals *- Under the appropriate columns, show the number of completed redeterminations, from Line 6 in which in which at least part of the prior determination decision was reversed. That is, a change was made and some part of the new determination was in favor of the appellant.* ***Note:*** *Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.*

Line 9.1. Number of Claims Partially Reversed – *Show the number of claims involved in Line 9 for which the decision is partially reversed.*

Line 9.1a – Report the number of SNF claims included in Line 9.1. Line 9.1b – Report the number of Home Health claims included in Line 9.1. Line 9.1c – Report the number of Inpatient Hospital claims included in Line 9.1. Line 9.1d – Report the number of Outpatient claims included in Line 9.1. Line 9.1e – Report the number of Lab claims included in Line 9.1. Line 9.1f – Report the number of Ambulance claims included in Line 9.1. Line 9.1g – Report the number of DME claims included in Line 9.1. Line 9.1h – Report the number of Physician claims reported in Line 9.1. Line 9.1i – Report the number of Other claims included in Line 9.1.

Line 10. Full Reversals *- Under the appropriate columns, show the total number of completed redeterminations from Line 6 in which the previous determination decision was completely reversed.* ***Note:*** *Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.*

Line 10.1. Number of Claims Fully Reversed – *Show the number of claims involved in Line 10 for which the decision is fully reversed.*

Line 10.1a – Report the number of SNF claims included in Line 10.1. Line 10.1b – Report the number of Home Health claims included in Line 10.1. Line 10.1c – Report the number of Inpatient Hospital claims included in Line 10.1. Line 10.1d – Report the number of Outpatient claims included in Line 10.1. Line 10.1e – Report the number of Lab claims included in Line 10.1. Line 10.1f – Report the number of Ambulance claims included in Line 10.1. Line 10.1g – Report the number of DME claims included in Line 10.1. Line 10.1h – Report the number of Physician claims reported in Line 10.1. Line 10.1i – Report the number of Other claims included in Line 10.1.

Line 11. Dismissals/Withdrawals *- Report, under the appropriate column, the number of cases from Line 6 that were withdrawn by the appellant or dismissed (before determination) by you.*

Line 11.1. Number of Claims Dismissed or Withdrawn – *Show the number of claims involved in Line 11.*

Line 11.1a – Report the number of SNF claims included in Line 11.1. Line 11.1b – Report the number of Home Health claims included in Line 11.1. Line 11.1c – Report the number of Inpatient Hospital claims included in Line 11.1. Line 11.1d – Report the number of Outpatient claims included in Line 11.1. Line 11.1e – Report the number of Lab claims included in Line 11.1. Line 11.1f – Report the number of Ambulance claims included in Line 11.1. Line 11.1g – Report the number of DME claims included in Line 11.1. Line 11.1h – Report the number of Physician claims reported in Line 11.1. Line 11.1i – Report the number of Other claims included in Line 11.1.

Notes:

Misrouted correspondence and duplicate requests are not dismissals.

If you have incorrectly counted such correspondence as an appeal on a previous report, use Line 2 (adjustments to pending) in the report for the subsequent month to correct the count.

Line 12. Number of Incomplete Redetermination Requests Dismissed - *Of those reported as dismissals in Line 11, enter the number of requests that were dismissed because the request was incomplete. For information on what constitutes an incomplete request, refer to the Medicare Claims Processing Manual, Publication 100-4; Chapter 29; Sections 40.2 and 60.11.1, and Change Request 3530.*

Line 13. Amount Reimbursed/Allowed - *For cases included in Line 6, show the reimbursed/allowed amount for services where the determination was reversed, either fully or partially. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.*

Line 13a. Waiver of Liability – *Of the amount recorded on Line 13, show the amount applicable to a waiver of liability payment, on the basis that the party did not know that the service wasn't payable under Medicare.*

Processing and Pending Times -This deals with processing and pending times for Part A and Part B appeals.

Computing Time to Process Redeterminations for (Lines 6 through 25)

For Lines 6-25, use the matrix below to determine the number of days from receipt to completion of redeterminations. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. In order to ensure that cases

are processed timely, cases should also be date stamped or controlled in some way in the mailroom.

Situation	***Date Completed***
o *The appellant withdraws the request.*	*The date the dismissal letter is mailed to the party.*
o *The contractor dismisses the request*	*The date the notice is mailed to the party.*
o *The contractor processes the request to a reversal.*	*For both full and partial reversals, when the contractor completes the action that sets in motion correct payment of the claim*

REDETERMINATIONS

PROCESSING TIME: REDETERMINATIONS WITH DOCUMENTATION SUBMITTED TIMELY

Line 14. Redetermination Processing Time – Average – *Report, under the appropriate columns, the average number of days from receipt of the redetermination in the corporate mailroom to the date of completion.*

To compute the average number of days from request to completion, divide the total days elapsed for all requests cleared in the month by the number of requests cleared. Round results to the nearest day. Calculate the days elapsed for an individual request by subtracting the Julian date of receipt from the Julian date of completion. If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number). If a case is cleared the same day it is received, consider it to require one day.

NOTE: Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

For Lines 15-25, consider the day of receipt to be Day 1.

Line 15. Redeterminations Completed in 31-60 Days *- Show the number of redeterminations that required 31-60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom).*

Line 16. Redeterminations Completed in over 60 Days *- Show the number of redeterminations that required more than 60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom).*

PROCESSING TIME: REDETERMINATIONS WITH DOCUMENTATION SUBMITTED AFTER REQUEST WAS RECEIVED

Note: *This section captures information in instances where the appellant submits additional documentation either on his or her own, or in response to a request for additional documentation through the development process. The contractor must receive the documentation in order for data to be entered into Lines 17-20.*

For Lines 17-20, consider the day of receipt to be Day 1.

Line 17. Redeterminations Processing Time - Average (Documentation Submitted Later) *– For redeterminations where documentation/evidence is submitted after the request is received, report under the appropriate columns, the average number of days from receipt of the redetermination to the date of completion.*

Line 18. Redeterminations Completed in 31-60 Days (Documentation Submitted Later) *- Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 31-60 days were required to complete the case.*

Line 19. Redeterminations Completed in 61-74 Days (Documentation Submitted Later) *- Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 61-74 days were required to complete the case.*

Line 20. Redeterminations Completed in over 74 Days (Documentation Submitted Later) *- Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and more than 74 days were required to complete the case.*

Line 21. Closing Pending Redeterminations - *Show, under the appropriate columns, the total number of redeterminations that have not been completed by the end of the reporting month.*

Line 22. Redeterminations Pending 1-30 Days *– Show the number of redeterminations included in Line 21 that have been pending for 1-30 days, inclusive, at the end of the reporting month.*

Line 23. Redeterminations Pending 31-60 Days *- Show the number of redeterminations included in Line 21 that have been pending 31-60 days, inclusive, at the end of the reporting month.*

Line 24. Redeterminations Pending 61-74 Days - *Show the number of redeterminations included in Line 21 which have been pending 61-74 days, inclusive at the end of the reporting month.*

Line 25. Redeterminations Pending Over 74 Days - *Show the number of redeterminations included in Line 21 which have been pending more than 74 days at the end of the reporting month.*

EFFECTUATION OF REDETERMINATION DECISIONS

Line 26. Total Effectuations *- Show the number of redetermination decisions for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you take the necessary actions to issue a payment to the appellant based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue.*

NOTE: In cases where it is necessary for an intermediary to seek written assurance, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs only after such written notice from the provider is received.

Line 26a. Number of Claims Involved – *Show the number of claims involved in Line 26.*

Line 27. Number Effectuated 1-30 Days - *Show the number of cases from Line 26 where you effectuated the decision within 30 days.*

Line 28. Number Effectuated 31-60 Days *- Show the number of cases from Line 26 where you effectuated the decision within 31- 60 days.*

Line 29. Number Effectuated Over 60 Days - *Show the number of cases from Line 26 where you effectuated the decision in more than 60 days.*

460.3 Section II - Qualified Independent Contractor (QIC) Reconsiderations

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

- Use Section II to report requests for reconsideration.

Reconsiderations, the second level of appeal, are processed by the QIC. This section of the report captures information related to several distinct pieces associated with the reconsideration process. While requests for reconsideration should be sent directly by the appellant to the QIC, it is probable that some requests will be sent to intermediaries and carriers, requiring the need for forwarding the request, and the associated case file, to the QIC. In those instances where the requests for reconsideration are sent directly to the QIC as required, the QICs will have to request case file information from the contractor before the reconsideration can be conducted. In addition, the contractor will effectuate QIC decisions, as appropriate.

***QIC RECONSIDERATIONS FALL INTO THE FOLLOWING CATEGORIES**:*

***Column (1)** Part A Cases- Use Column 1 to record information on reconsiderations of redeterminations for Part A services processed by the intermediary.*

***Column (2)** Part B of A Cases Use Column 2 to record information on reconsiderations of redeterminations for Part B services processed by the intermediary.*

***Column (3)** Part B Cases- Use Column 3 to record information on reconsiderations of redeterminations for Part B services processed by the carrier.*

***Line 30. Opening Pending** - Show the number of closing pending reconsiderations reported on Line 47 on the previous month's report.*

***Line 31. Adjustments to Pending** - If it is necessary to revise the pending figure for the close of the previous month because of inventories or reporting errors, enter the adjustment. Report requests received near the end of the reporting month and placed under control in the subsequent month as received in the reporting month, not as requests received in the subsequent month. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending in the subsequent month.*

***Line 32. Adjusted Opening Pending** - Show the result of Line 30 + Line 31 (taking into account the "-" sign, if any).*

***Line 33. Requests for QIC Reconsideration Received by the Contractor** - Show the number of QIC reconsiderations received by the contractor during the month. Although the requests for reconsideration should be sent directly to the QIC, some cases may be sent directly to the contractor instead. Enter the number reconsideration requests sent by*

the appellant or their representative directly to the contractor. The contractor must forward these requests, along with the associated case file, to the QIC.

Line 34. Requests from QIC for Case Files: *Upon receipt of the request for reconsideration, the QIC must contact the contractor to request the case file. Show the number of requests for case files received by the contractor from the QIC during the month. Requests can be received in the corporate mailroom, by telephone or by fax.*

Line 35. Number Case Files Forwarded to QIC *- Show the number of reconsideration case files forwarded to QICs during the month. Consider the case forwarded when all necessary material has been mailed to the QIC.*

Line 36. Number Forwarded In 5-7 Days *- Show the number of Reconsideration case files forwarded to QICs in 5-7calendar days from receipt of the request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.*

Line 37. Number Forwarded In Over 7 Days *- Show the number of Reconsideration case files forwarded to QICs in over 7 calendar days from receipt of the request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.*

Line 38. Average Time to Forward *- The average number of calendar days from receipt of the QIC request to the date of mailing of the necessary information. Refer to instructions contained in Line 14 to determine average time to forward.*

Line 39. Pending Case File Requests – *Show the number of case files yet to be forwarded to the QIC. This could include requests received from, but not yet sent to the QIC, as well as those reconsideration requests being sent by the contractor to the QIC in response to a request for reconsideration.*

Disposition of QIC Decisions

Line 40. Number Reconsiderations Completed (and received From QIC)- *Show the number of Reconsideration requests completed during the month. Consider a case completed when you have received the completed decision from the QIC for all parts of the case.*

Line 41. Number Completed Reconsiderations That Need Effectuation *- Show the number of Reconsideration cases from Line 40 for which an effectuation action must be taken.*

41a. Number of Claims Involved: *Show the number of claims involved in Line 41.*

Line 42. Amount Reimbursed/Allowed - *For cases included in Line 41 show the reimbursed/allowed amount for services where the determination was reversed, either fully or partially. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.*

Line 42a. Waiver of Liability – *Of the amount recorded on Line 42, show the amount applicable to a waiver of liability payment on the basis that the party did not know that the service wasn't payable under Medicare.*

EFFECTUATION OF QIC DECISIONS

Line 43. Total Effectuations *- Show the number of Reconsideration decisions for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you take the necessary actions to issue a payment to the appellant based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue.*

NOTE: In cases where it is necessary for an intermediary to seek written assurance, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs only after such written notice from the provider is received.

Line 43a. Number of Claims Involved – *Show the number of claims involved in Line 43.*

Line 44. Number Effectuated in 1-30 Days - *Show the number of cases from Line 43 where you effectuated the decision within 30 days. Effectuation days include day of receipt of the decision in your corporate mailroom or electronic transmission, such as fax or secure e-mail.*

Line 45. Number Effectuated in 31-60 Days - *Show the number of cases from Line 43 where you effectuated the decision within 31-60 days.*

Line 46. Number Effectuated in Over 60 Days - *Show the number of cases from Line 43 where you effectuated the decision in more than 60 days.*

Line 47. Closing Pending Reconsiderations - *Show the total number of reconsideration requests that were not completed by the end of the reporting month. Consider a case pending from the date of receipt of the request, or request for the case file, until you have received the completed decision from the QIC for all parts of the case. This number shall also reflect those case files not yet forwarded to the QIC by the contractor as well as those decisions that have been received by the contractor from the QIC that still require some action on the part of the contractor.*

460.4 – Section III- Administrative Law Judge Results

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

Line 48. Opening Pending *- Show the number of ALJ cases reported on Line 57 as the closing pending on the previous month's report.*

Line 49. Number ALJ Requests Misrouted to Contractor – *Report the number of ALJ requests that were misrouted to the contractor when they should have been filed with the Office of Medicare Hearings and Appeals instead.*

Line 50. Number ALJ Cases Completed and Received From Administrative QIC - *Show the number of ALJ hearings completed during the month. Consider a case completed when you have received the completed decision from the Administrative QIC for all parts of the case.*

Line 51. Number Completed that need Effectuation *- Show the number of ALJ hearings from Line 50 for which an effectuation action must be taken.*

Line 52. Amount Reimbursed/Allowed *- For cases included in Line 51, show the reimbursed/allowed amount for services where the initial determination was reversed, either fully or partially. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.*

Line 52a. Waiver of Liability – *Of the amount recorded on Line 52, show the amount applicable to a waiver of liability payment on the basis that the party did not know that the service wasn't payable under Medicare.*

Line 53. Total Effectuations *-Show the number of ALJ decisions effectuated during the month. Consider effectuation of a decision to occur when you take the necessary actions to issue payment based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue.*

NOTE: In cases where it is necessary for an intermediary to seek written assurance, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs only after such written notice from the provider is received.

Line 53a. Number of Claims Involved – *Show the number of claims involved in Line 53.*

Line 54. Number Effectuated in 1-30 Days - *Show the number of cases from Line 53 where you effectuated the decision within 30 days. Effectuation days include day of receipt of the decision in your corporate mailroom.*

Line 55. Number Effectuated in 31-60 Days - *Show the number of cases from Line 53 where you effectuated the decision within 31-60 days.*

Line 56. Number Effectuated in Over 60 Days *- Show the number of cases from Line 53 where you effectuated the decision in more than 60 days.*

Line 57. Closing Pending ALJ Cases *- Show the total number of ALJ requests that were not completed by the contractor at the end of the reporting month, and as such, are still pending.*

460.5 - Section IV – Department Appeals Board (DAB) Effectuations

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

Line 58. DAB Effectuations – *Show the total number of cases received from the DAB which require effectuation by the contractor. While it is acknowledged that contractors will not have responsibility for forwarding these cases to the DAB, information is requested since the contractor will have ultimate responsibility to make payment.*

460.6 - Clerical Error Reopenings

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

When a determination is made on a claim for services, the beneficiary (and the provider, physician or other supplier of medical services) should be able to rely on the fact that the coverage decision and payment amount are correct. Occasionally, information disclosing an error (on the part of the appellant or the contractor) in the determination comes to light after the payment has been denied. Regulations do not permit unrestricted reopening of determinations and decisions, but rather, set specific circumstances under which a determination or decision may be reopened. Refer to 42 Code of Final Regulations (CFR) 405.980-986, Interim Final Rule, dated March 8, 2005.The Reopening section of the report focuses primarily on those clerical error and minor omission reopenings that occur at the pre and post redetermination level. It is not intended to address other types of reopenings, e.g., claims reopenings or those reopenings handled in Medical Review for failure to submit required medical documentation. Contractors should continue to use the appropriate columns and lines of the CMS 2591 and CMS 2590 reports to capture data on reopenings that are not clerical in nature.

Note**: **Clerical Error Reopenings data requested in this section should be reported in claims, not cases.

Line 1. Total Number of Clerical Error Reopenings Processed -- *Show the total number of reopenings processed by the contractor during the month.*

Line 2. Total Number Processed – Own Motion – *Of the number reflected on Line 1, show the number the contractor reopened the claim on their own motion.*

Line 3. Total Number Processed – Claimant Initiated – *Of the number reflected on Line 1, show the number of reopenings initiated by the claimant.*

Line 4. Total Number Reopenings Resulting From Contractor Error -- *Of the reopenings reflected in Line 1, show the total number of claims that were the result of contractor error, whether discovered by the contractor or the claimant.*

Line 5. Total Number Reopenings Resulting From Provider Error -- *Of the reopenings reflected in Line 1, show the total number of claims that were the result of provider error, whether discovered by the contractor or the claimant.*

Line 6. Clerical Error Reopenings at the Pre-Redetermination Level – *Of the number reflected in Line 1, show the number that occurred before the redetermination was conducted.*

Line 7. Clerical Error Reopenings at the Post-Redetermination Level – *Of the number reflected in Line 1, show the number that occurred after the redetermination was conducted.*

Line 8. Total Number Initial Determinations Revised on Reopening *Of the number shown in Line 1, show the total number for which the initial determination decision was changed in some way.*

Line 9 Number Dismissed—*Of the number shown on Line 1, show the number required to be dismissed under the regulations noted in this section because they are not clerical errors.*

Line 10. Amount Reimbursed/Allowed *– Of the number shown on Line 8, show the reimbursed/allowed amount for services where the determination was reversed, either fully or partially. Show changes prior to the application of the deductible and coinsurance. Round results to the nearest dollar.*

Line 10a. Waiver of Liability -- *Of the amount recorded in Line 10, show the amount applicable to a waiver of liability payment, on the basis that the party did not know the service wasn't payable under Medicare.*

Line 11: Total Number Reopening Requests Transferred to Other Component within the Contractor*: Of the number reflected on Line 1, show the number that were transferred to another area of the contractor (claims, appeals inquiries, MSP, MR). The CMS 2592 is designed to track clerical error reopenings only. Line 11 captures those instances where the reopening is more complex or falls under another category.*

Note: Time frames noted in Lines 12 and 13 are for clerical error reopenings only. No time frames have been established for other types of reopenings

12. Reopenings Processed in 1-30 Days – *Show the number of clerical error reopenings from Line 1 processed in 1-30 days.*

13. Reopenings Processed in 31-60 Days - *Show the number of clerical error reopenings from Line 1processed in 31-60 days.*

Line 14. Total Number Reopening Requests Pending –*Show the number of clerical error reopenings pending at the close of the reporting month.*

Line 15. Total Number Reopening Occurring at Higher Level of Appeal – *Of the number shown on Line 1, show the total number that were reopened by the QIC, ALJ or DAB.*

Line 15a. Total Number Higher Level Reopenings Requiring Adjustment by the Contractor – *Of the number shown in Line 15, record the number of claims that require an adjustment by the contractor.*

Line 16. Amount Awarded *– Show the allowed amount for services from Line 15a where the determination was reversed, either fully or partially. Show changes prior to the application of the deductible and coinsurance. Round results to the nearest dollar.*

460.7- Validation of Reports

(Rev. 76; Issued: 08-12-05; Effective: 04-01-06; Implementation: 04-03-06)

Before sending the reports to CMS, check for completeness and arithmetical accuracy. Note that the information provided below is applicable to each separate column. Use the following checklist for an arithmetical check for each column:

- *Line 1 equals Line 21 from previous month's report.*
- *For each column, Line 1 plus Line 2 equals Line 3.*
- *The total of Line 6.1a through 6.1i equals Line 6.1.*
- *The total of Line 7.1a through 7.1i equals Line 7.1.*
- *The total of Line 8.1a through 8.1i equals Line 8.1.*
- *The total of Line 9.1a through 9.1i equals Line 9.1.*

- *The total of Line 10.1a through 10.1i equals Line 10.1.*
- *The total of Line 11.1a through 11.1i equals Line 11.1.*
- *Line 6.1 is equal to or greater than Line 6.*
- *Line 7.1 is equal to or greater than Line 7.*
- *Line 8.1 is equal to or greater than Line 8.*
- *Line 9.1 is equal to or greater than Line 9.*
- *Line 10.1 is equal to or greater than Line 10.*
- *Line 11.1 is equal to or greater than Line 11.*
- *Line 12 must be less than or equal to Line 11.*
- *Line 8 plus Line 9 plus Line 10 plus Line 11 must not exceed Line 6.*
- *Line 13a must not exceed Line 13.*
- *Line 15 plus Line 16 must not exceed Line 6.*
- *Line 18 plus Line 19 plus Line 20 is equal to or less than Line 6.*
- *Line 27 plus Line 28 plus Line 29 equals Line 26.*
- *Line 22plus Line 23 plus Line 24 plus Line 25 equals Line 21.*
- *Line 30 equals Line 47 of the previous month's report.*
- *Line 30 plus Line 31 equals Line 32.*
- *Line 36 plus Line 37 must not exceed Line 35.*
- *Line 41a is equal to or greater than Line 41.*
- *Line 42a must not exceed Line 42.*

- *Line 43a is equal to or greater than Line 43.*
- *Line 44 plus Line 45 plus Line 46 equals Line 43.*
- *Line 48 equals Line 57 from the previous month's report.*
- *Line 52a must not exceed Line 52.*
- *Line 53a is equal to or greater than Line 53.*
- *Line 54 plus Line 55 plus Line 56 equals Line 53.*
- *Line 2 (Reopenings) plus Line 3 (Reopenings) equals Line 1 (Reopenings)*
- *Line 4 (Reopenings) must not exceed Line 1 (Reopenings)*
- *Line 5 (Reopenings) must not exceed Line 1 Reopenings)*
- *Line 10a (Reopenings) must not exceed Line 10 (Reopenings)*
- *Line 12 (Reopenings) plus Line 13 (Reopenings) must not exceed Line 1 (Reopenings)*
- *Line 15a (Reopenings) must not exceed Line 15 (Reopenings)*